STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155269	A. BUILDING 00 B. WING	01/30/2013

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EAST LAKE NURSING AND REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

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F0000	This visit was for the Investigation of Complaint #IN00123135 and #IN00123289. Complaint #IN000123135 - Substantiated Federal/State findings related to the allegations are cited at F157 and F309. Complaint #IN000123289 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 25, 28, 29, and 30, 2013 Facility number: 000169 Provider number: 155269 AIM number: 100267100 Survey team: Julie Wagoner, RN Census bed type: SNF: 04 SNF/NF: 131 Total: 135 Census payor type: Medicare: 22 Medicaid: 89 Other: 24 Total: 135	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after March 1, 2013.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 07 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on February 8, 2013, by Brenda Meredith, R.N.			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interviews, the facility failed to ensure a family member was notified of all of their family member's falls for 1 of 4 residents reviewed for falls in a	F0157	**F157 – Notification of Changes (Injury/Decline/Room, etc)** It is the practice of this provider to promptly notify the resident, consult with resident's physician, notify resident's legal	03/01/2013

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	sample of 7. (Resident C) Finding includes: 1. The clinical record for Resident C was reviewed on 01/25/13 at 2:00 P.M. Resident C was admitted to the facility on 04/02/12. Review of nursing progress notes and fall event documentation, dated 11/25/12 at 1:42 A.M. and 1:52 A.M., indicated Resident C was found on the floor in his room. The physician was notified and documentation indicated Resident C's POA (power of attorney) was to be notified the following shift. Nursing notes on 11/25/12 - 11/26/12, indicated there was no documentation Resident C's POA was notified of the resident's fall. Nursing progress notes and fall event documentation and fall circumstance reports, dated 12/18/12 at 2:50 A.M., indicated Resident C was again found in his room on the floor. The physician was notified and Resident C's POA was to be notified the following shift. Review of nursing progress notes for 12/18/12 and 12/19/12, indicated there was no documentation Resident C's POA was notified of his fall. Interview with Resident C's POA, on		representative or interested family when there is a significant condition change in the resident's physical, mental or psychosocial status and/or the need to alter treatment. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident C* – family has been made aware of all falls for this resident to date. The resident has experienced no negative outcome as a result of this finding. Resident's family will be notified if any fall or change of condition should occur. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by this finding. A chart audit will be conducted by the Nurse Management Team to ensure the physician, family and/or responsible party has been notified regarding any change in resident condition including falls/injuries. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be conducted by the DNS/designee on or before 3/1/13. This in-service will include review of the facility policy titled, "Resident Change in Condition". This in-service will also include review	

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	01/25/13 at 12:35 P.M., confirmed she had not been notified of all of Resident C's recent falls. This Federal tag relates to Complaint #IN000123135 3.1-5(a)(1)		of the facility policy and procedure for family/POA notification guidelines for any change in resident condition such falls/injuries. Continued compliance with prompt notification will be monitored through review of nursing progress notes and physician orders during the daily clinical meeting by the DNS/designee to ensure proper follow up and notifications have occurred. Nurse Manager will monitor progress notes on the week-end to ensure physican and family are notified of any change in condition. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Tool titled, “Change in Condition” daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By whatdate the systemic changes will be completed:*** Compliance Date: 3/1/13	

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interviews, the facility failed to ensure the physical condition of 4 of 7 residents was thoroughly and/or timely assessed when a change of condition occurred. (Residents C, D, F, and G) Findings include: 1. The clinical record for Resident F was reviewed on 01/28/13 at 10:00 A.M. Resident F was readmitted to the facility on 07/30/12, with diagnoses, including but not limited to, skin irritation, hypertension, diabetes mellitus, coronary artery disease, anemia, and peripheral vascular disease (PVD), and had a history of a Cerebral Vascular accident (CVA). A nursing progress note, dated 01/16/13 at 1:09 P.M., indicated the following: "Resident noted with wet cough and white frothy sputum. Lungs sound congested bilateral. MD	F0309	**F309 – Provide Care Services for Highest Well Being** It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident C, D, G* – have been seen by their attending physician to ensure each resident's physical well-being.Residents have been assessed, and care plans and Nurse Aide Assignment Sheets have been updated to reflect each resident's current status.These residents experienced no negative outcome related to this finding. *Resident F* – has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the	03/01/2013

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	notified. New order for cxr given and received. Family notified. Will cont (continue) to monitor." Physician orders, dated 01/16/13, indicated an order for a chest xray was obtained. The care plan update below the physician's order indicated the xray was due to a "wet cough" and the intervention was to "follow above order [for chest xray]." The chest xray results from 01/16/13 indicated "Moderate cardiomegaly and minimum congestive failure." A nursing progress note, dated 01/17/13 at 10:37 A.M., and printed per request on 01/30/13 at 11:07 A.M., indicated the following: "Resident alert an combative with care. New order received to obtain BNP [B-type Natriuretic Peptide blood test used to gauge heart failure] d/t [due to] CXR [chest xray]results. Family notified. Ma [sic] assist provided with care. Up in geri-chair at this time. Will cont to monitor." Another physician's order, dated 01/17/13, indicated a BNP blood test x1 (one time) was to be obtained. The care plan update below the physician's order indicated "minimum congestive failure" with an intervention to "Follow above order"		potential to be affected by this finding.The DNS/designee will conduct a chart audit of all residents to ensure any resident with a change in condition is properly assessed, monitored closely with appropriate follow up assessments and documentation as well as proper notification until the resident's condition has stabilized/resolved.A nursing in-service will be held on or before 3/1/13. The DNS/designee is responsible for conducting this in-service.This in-service will include review of the facility policy related to assessments, documentation and follow up to any resident change in condition such as acute illness, transfer of a resident to an acute care setting, administration, assessment and documentation of residents requiring pain medication and assessment of vital signs during a seizure. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 3/1/13.The DNS/designee is responsible for conducting this in-service.This in-service will include review of thefacility policy related to assessments, documentation and follow up to any resident change in condition such as acute illness, transfer of a resident to an acute care setting, administration, assessment and documentation	

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	as the intervention. A nursing progress note, dated 01/18/13 at 6:52 P.M., indicated the following: "Resident awake and yelling out at times. No complaints of pain or discomfort at this time. Skin warm and dry. Dressing to left foot clean, dry and intact with no drainage noted. Resident cooperative with staff this shift. No behaviors noted at this time. Resident appears to have stuffiness noted with complaints of headache at times. Spoke with DR [doctor] and new orders received for Claritin daily. Spoke with daughter [name] concerning new order. Family thankful for call." Another physician's order, dated 01/18/13, indicated the allergy medication, Claritin was ordered to be given daily. The care plan update below the order indicated "head congestion and ache" as the reason for the order and the intervention "order as above" was listed as the only intervention. Nursing progress noted from 01/19/13 - 01/25/13, indicated there was no mention of the resident's respiratory status, stuffiness, or chest congestion. The resident's pain was mentioned but mainly regarding the		of residents requiring pain medication and assessment of vital signs during a seizure.Review of nursing progress notes,assessments and physician orders will be reviewed during the daily clinical meeting by the DNS/designee, to ensure proper follow up is provided for any resident change in condition and notifications of physician and family have occurred.Nurse manager on the weekend will ensure residents are assessed timely and physician and family notified when a change of condition occurs. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Tool titled, “Change in Condition” daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months.If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By whatdate the systemic changes will be completed:*** Compliance Date:3/1/13.	

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	pain in the resident's foot which had developed pressure areas. The resident was also sent to an acute care facility to replace a gastrostomy feeding tube. Nursing progress notes, on 01/26/13 at 12:53 P.M., indicated the following: "Resident alert. Max [Maximum] assist provided with care. Assisted x2 to geri-chair. Meds given as directed. Resident noted with yelling out and grabbing staff. Not easily re-directed. Non-complaint with O2 therapy [oxygen]. Tx [treatment] to left heel done per order. Redness to lateral 5th toe remains. Scheduled pain meds given as directed. Will cont to monitor." Nursing progress notes, on 01/26/13 at 12:53 P.M., indicated the following: "Resident alert. Max assist provided with care. Assisted x2 to geri-chair. Meds given as directed. Resident noted with yelling out and grabbing staff. Not easily re-directed. Non-complaint with O2 therapy [oxygen]. Tx [treatment] to left heel done per order. Redness to lateral 5th toe remains. Scheduled pain meds given as directed. Will cont to monitor." A physician's order, dated 01/26/13 at			

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	2:00 P.M., indicated the following: "Obtain chest x-ray for f/u [follow up] CHF [congestive heart failure]." The care plan update below the order indicated "congestive f/u" as the reason for the order with "repeat chest x-ray" as the intervention. The chest xray results, dated 01/26/13, indicated "pulmonary vascular congestion....in both lower lung fields. Clinical correlation is requested....." A nursing progress note, dated 01/26/13 at 2:03 P.M., indicated the following: "Resident in bed with HOB [head of bed] elevated 45 degrees. Lungs diminished throughout. Moist cough, nonproductive. Resp [respirations] even and nonlabored. O2 sat (blood saturation level) 91 % ON 2 liters n/c [nasal cannula]. Temp 97.6. Denies pain. Wife here. Condition report given. MD notified and new order obtained to perform chest x ray today...." Finally, on 01/26/13 at 6:40 P.M., an order was received to send the resident to the acute care center for an evaluation and treatment. The attached care plan update indicated "Increase congestion and change in CXR" as the reason for the order. A nursing progress note, dated			

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	01/26/13 at 7:44 P.M., indicated the physician was notified of the chest xray results and ordered a one time extra dose of a diuretic medication to be given. However, the resident's daughter indicated she was notifying another physician of Resident F's condition and eventually an order was received to transfer the resident to an acute care center where he was admitted for further testing. On 01/29/13 at 2:30 P.M., Resident F's pressure areas were observed. During the observation, Resident F was noted to barely be responsive and had audible lung congestion when he breathed. A nursing progress note, printed on 01/28/13 at 2:05 P.M., and not present chronologically in the nursing notes printed on 01/30/13, indicated a weekly summary had been completed by the unit manager on 01/18/13 at 2:27 A.M. The summary indicated the following: "...Res LS [lung sounds] clear/diminished lower lobes bilat neb (nebulizer) treatment cont [continue] q [every] 4 hours as ordered...." The electronic event history charting for Resident F, from 01/16/13 through 01/28/13, indicated there were 5			

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	entries related to pressure area assessments and one entry on 01/28/13, for 72 hour readmission charting. There was no event history "hot charting" for Resident F regarding his respiratory status and congestive heart failure issues. Review of the SBAR reports (Physician/NP/PA Communication and Progress Note) for Resident F for January 2013, obtained from the Director of Nurses office on 01/30/13 at 11:30 A.M., indicated there was an undated SBAR report regarding the resident pulling out his G-tube. There were vital signs and the resident's lung sounds were documented as "coarse." The other SBAR report, completed on 01/26/13 at 6:40 P.M., indicated the resident was short of breath and had a cough, no lung sounds were assessed, his temperature was elevated at 99.8 degrees Fahrenheit, his skin was pale and he had increased pain to his head and chest. There were no other thorough, consistent assessments provided for Resident F who had physician orders received, starting on 01/16/13 through 01/26/13, regarding head and lung congestion.			

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	2. The clinical record for Resident C was reviewed on 01/25/13 at 2:00 P.M. Resident C was admitted to the facility on 04/02/12. The resident had diagnoses, including but not limited to, PVD, coronary artery disease, hypertension, and chronic pressure ulcers. Nursing progress notes, dated 12/18/12 at 3:07 A.M., indicated the resident was found in his room on the floor. A nursing note, indicated 12/18/12 at 12:03 P.M. indicated the resident had no visible injuries from the fall but was referred to therapy due to an increase in weakness and requiring more assistance for transfers. The note also indicated the resident had been "lethargic" but "arousable." Vital signs were also assessed at the time of the follow up assessment. Nursing progress notes, dated 12/19/12 at 9:29 A.M., indicated the Certified nursing assistants had informed the nurse of the resident's increased weakness, lethargy, and increased need for assistance with Activities of Daily Living. The note indicated the physician and family had been updated. There was no further nursing note or			

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	assessment documented in the nursing notes until 12/19/12 at 6:24 P.M. when a note indicated the resident's family was in the building and requested the resident be sent out as he was less responsive and sluggish, had increased pain and stiffness in his left leg. The physician was notified again and ordered a STAT (immediate) CBC and CMP blood test and an antibiotic to be given for 7 days due to a possible toe/heel wound infections. However, the family indicated they still preferred the resident to be sent to the acute care facility and the physician was notified of their wishes. A physician's order was then obtained to send the resident out to the acute care facility for evaluation. Review of the Events reports, from 12/18/12 - 12/19/12, indicated a fall event report was completed for the fall the resident incurred on 12/18/12 at 3:07 A.M. The fall event report had included vital signs assessed and documented on 12/18/12 at 3:05 A.M., 12:02 P.M., and at 10:13 P.M. The 12/18/12 assessment completed at 12:03 P.M., included documentation regarding the resident's weakness and lethargy and a referral to therapy was made.			

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EAST LAKE NURSING AND REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

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	Interview with the Director of Nursing, on 01/28/13 at 11:30 A.M., indicated the resident was placed on "Hot charting" on 12/19/12 at 9:44 A.M. Review of the Hot Charting form, dated 12/19/12 at 9:44 A.M. indicated the resident was to be "Monitor for weakness/increase need for help with ADL's [Activities of Daily Living]." There was no further assessment documentation noted on the form and no further "Hot charting" documentation for Resident #C. Review of the Discharge/Appointment/Transfer form for Resident C, initiated on 12/19/12 at 5:53 P.M. and completed on 12/19/12 at 6:18 P.M., indicated the resident was being discharged due to a "change of condition, severe pain to left leg, sluggish. There was no specific assessment documentation of the resident's condition. However, the resident usual status was documented on the transfer form and assistive devices required. On 01/29/13 at 10:03 A.M., a hand documented form, titled, SBAR (physician/NP/PA Communication and Progress Note, was presented by the Director of Nursing (DON). The DON indicated the forms were utilized to ensure the nursing staff had all the			

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	information available before they called the physician. She indicated the forms were located in a stack of papers in her office. She indicated after she reviewed the forms to audit the information they were filed in the medical records files for the residents. Review of the form for Resident C, dated 12/19/12 at 5:45 P.M., indicated the resident was groggy, lethargic, and had severe pain in his left leg, a possible infection in left foot diabetic ulcer, vitals were assessed and within normal range, no lung sounds were assessed. A progress note on the form, dated 12/19/12 at 5:30 P.M., indicated the following: "New orders received for STAT CBC and CMP and to start Clindamycin [an antibiotic] QID x 7 fays for possible wound infection to l [left] foot. Daughter [name] notified of orders received. Daughter then states "that's not good enough. Either you have him sent out or I will." Call placed to (physician's name) with above mentioned. (Physician's name) then gave order to send out to ER (emergency room). Family aware. Tri county (ambulance service) notified and will be here within 30 minutes. Report called to (nurse's name) at EGH (initials for local hospital name) ER.			

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	Review of the history and physical assessment for Resident C, dated 12/19/12, indicated the resident presented with a temperature of 102.9 degrees, a heart rate of 117, and blood pressure of 160/70. The resident was assess to have an "altered mental status likely secondary to a urinary tract infection...elevated troponin...likely secondary to his underlying infection....." The December 2012 Medication Administration Record indicated although the resident had complaints of severe pain in his left leg, he was not medicated with any available pain medication. 3. The clinical record for Resident D was reviewed on 01/25/13 at 2:50 P.M. Resident D was admitted to the facility on 01/10/12, with diagnosis, including but not limited to, dementia - lewy body type, and history of cerebral vascular accident. Review of nursing progress notes, dated 01/11/13, at 7:40 A.M., indicated the following: "Resident presented with emesis and loose stools. Max assist given with care. Resident stated "I don't feel good."			

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	Afebrile at this time, O2 [oxygen] applied per order due to biox [blood oxygen level] at 88 % on RA [room air]. MD called. No answer received. Left message awaiting return call." The next nursing note was completed on 01/11/13 at 12:57 P.M. and indicated the following: "Call received from [physician's name]. New orders given. Son [name] informed of resident condition." The next nursing note, also in the hot charting, completed on 01/11/13 at 11:12 P.M. indicated "Looses [sic] stools continued this shift. Some emesis noted. Resident refused supper and po [oral] fluids. Resident noted to be having small seizures. Spoke with [Physician's name] who gave order to send resident to ER for eval and treatment." The SBAR note for Resident D, initiated on 01/11/13 at 6:45 P.M. and completed on 01/11/13 at 7:45 P.M., indicated the physician was notified at 6:15 P.M. of the resident "appears to be having many seizure like episodes." Upon assessment resident noted laying in bed staring (sic) straight ahead. Resident looks towards voice when spoken to. Does not attempt to speak noted within			

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	minutes resident's eye rolled back and resident nonresponsive. Continues to breath normally. Call placed to ER 911 contacted. 7:00 P.M. - Elkhart EMS in and transported resident to ER. The front of the form indicated around 5:45 P.M. the resident started having "multiple mini seizures." There were no nursing notes, vitals, oxygen levels assessed during the seizures. The SBAR was located in the DON's office. Review of the "Know it all" data collection system, dated 2010, utilized by the facility as a reference, indicated for seizure activity or convulsions the following physical data should be gathered included "vital signs, details [location, duration, severity, recurrence, etc] of any seizure activity, including localized or generalized motor activity, bowel or bladder incontinence, behavioral changes, loss of consciousness, details of nay injury or complications associated with the seizure activity, any signs and symptoms associated with any medication condition related to the patient's seizure disorder [muscle twitching due to hypocalcemia,etc.], and neurological evaluation after seizure activity."			

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	4. The clinical record for Resident G was reviewed on 01/28/13 at 10:20 A.M. Resident G had diagnoses, including but not limited to, obesity and mental retardation. Nursing progress note, dated 10/22/12 at 8:48 P.M., indicated the following: "Resident c/o [complains] pain to right ear. [Physician name] notified. New orders received and noted. Left a message for POA. Prn [as needed] pain medication given with relief. Resident resting in bed with eyes closed." An order was received, on 10/22/12 at 7:30 P.M., for Colace liquid 1 ml into right ear wait 20 minutes then flush with body temperature water. May repeat x1 if no results." There were no further nursing progress notes or event history notes related to the condition of the resident's right ear and no assessment completed regarding the resident's ear. This Federal deficiency relates to Complaint #IN00123135. 3.1-37(a)			

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